DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DEC 2 2 2008

Mr. Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capital Avenue, MS 0000
P. O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Douglas:

Enclosed is our final report (Control Number 09-FM-2006-CA-003 DMHOP), "Review of California Department of Mental Health Over-Billing in the Short Doyle Medi-Cal Program for State Fiscal Year 2003/2004".

The purpose of our review was to determine whether the mental health overpayment reconciliation for State Fiscal Year 2003/2004 reported by the California Department of Health Care Services on the June 30, 2006, Centers for Medicare & Medicaid Services' Quarterly Expenditure Report was accurately calculated, reported and supported by appropriate documentation.

We received your response, dated November 14, 2008, to the CMS draft report. DHCS agreed with the report's recommendations. Additionally, in your response you requested the opportunity to further review the SFY 03/04 beneficiary mental health data to determine the amount that must be returned to CMS. CMS is unable to approve this request and requests that DHCS make the Line 10B adjustment for $8,533,137 within 60 days in accordance with 433.312. If, however, the State's subsequent review results in changes to the overpayment amount, adjustments can be made in accordance with 42 CFR 433.312(f).

A copy of your letter has been incorporated into the enclosed final report.

Should you or your staff have any questions regarding this matter, please contact Brian Burdullis at (916) 498-6523 or e-mail him at: Brian.Burdullis@cms.hhs.gov.

Sincerely,

Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Traci Walter, Audit Coordinator

REVIEW OF CALIFORNIA DEPARTMENT OF MENTAL HEALTH OVER-BILLING IN THE SHORT DOYLE MEDI-CAL PROGRAM FOR STATE FISCAL YEAR 2003/2004

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF MENTAL HEALTH

Control Number: 09-FM-2006-CA-003-F

DECEMBER 2008

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO REGIONAL OFFICE

EXECUTIVE SUMMARY

OBJECTIVE

The objective of this review was to determine whether the mental health overpayment reconciliation for state fiscal year (SFY) 2003/2004 reported by the California Department of Health Care Services (DHCS) on the June 30, 2006 Centers for Medicare & Medicaid Services' (CMS) Quarterly Expenditure Report (CMS-64) was accurately calculated, reported and supported by appropriate documentation.

BACKGROUND

In a letter dated April 3, 2006, the State of California notified CMS that the California Department of Mental Health (DMH), a sister state agency to DHCS, had identified approximately $30 million in overpayments of Federal financial participation (FFP), primarily due to double billing for Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) during state fiscal year (SFY) 2003/2004. On May 19, 2006, CMS responded with a request that DHCS finalize the overpayment amount and return the overpayment through a Line 10B Adjustment on the CMS-64 for the quarter ending June 30, 2006.

When the June 30, 2006, CMS-64 was certified by DHCS, it reflected overpayment adjustments related to this issue in excess of $130 million FFP. Because of the significant difference between the estimate and the actual amount returned to CMS, a financial management review was scheduled to review the computation of the amount returned.

FINDINGS

1. The State was unable to support an additional $8,533,137 of the FY 2003/2004 beneficiary mental health service costs claimed on the June 30, 2006 CMS-64. This was due to the inclusion of claims that had not been paid by the DMH for FY 2003/2004.

2. DMH non-Title XIX (i.e., Title XXI or State-only programs) and administrative expenditures have been inappropriately claimed as Title XIX Medical Assistance Payments.

3. DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health consolidation waiver expenditures reported on the CMS-64 forms to likely be significantly misstated.

4. DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices.

RECOMMENDATIONS

1. DHCS must return the additional $8,533,137 FFP for FY 2003/2004 overpayments.

2./3. DMH must review the DMH cost settlements reported for SFY 01/02, 02/03, and 03/04 and return Title XIX Medicaid FFP claimed for State-only programs and SCHIP. We estimate the total adjustment will be $12.42 million in FFP. We also recommend that DHCS implement controls to properly report cost settlement amounts.

4. We recommend the State implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

STATE RESPONSE

DHCS responded, dated November 14, 2008, to the CMS draft report that it was in agreement with the report's recommendations. In the State's response, DHCS requested the opportunity to further review the SFY 03/04 beneficiary mental health data to determine the amount that must be returned to CMS. CMS is unable to approve this request and has requested that DHCS make the Line 10B adjustment for $8,533,137 within 60 days in accordance with 433.312. If the State's review results in changes to the overpayment amount, future adjustments can be made in accordance with 42 CFR 433.312(f). A copy of the State's response is attached to the report.

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INTRODUCTION

OBJECTIVE

The objective of this review was to determine whether the mental health overpayment reconciliation for state fiscal year 2003/2004 reported by the California Department of Health Care Services (DHCS) on the June 30, 2006, Centers for Medicare & Medicaid Services' Quarterly Expenditure Report (CMS-64) was accurately calculated, reported and supported by appropriate documentation.

BACKGROUND

Department of Mental Health Overpayment

In a letter dated April 3, 2006, the State of California notified CMS that the California Department of Mental Health (DMH), a sister state agency to DHCS, had identified approximately $30 million in overpayments of Federal financial participation (FFP), primarily due to double billing for Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) during state fiscal year (SFY) 2003/2004. On May 19, 2006, CMS responded with a request that DHCS finalize the overpayment amount and return the overpayment through a Line 10B Adjustment on the CMS-64 for the quarter ending June 30, 2006.

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California Medicaid Mental Health Services

Most Medicaid mental health services in California are provided through 56 county mental health plans (MHPs) that contract with the California Department of Mental Health as non-risk, prepaid inpatient health plans (PIHPs) under a Section 1915(b) waiver. These MHPs provide specialty mental health services that the State refers to as "Short-Doyle/Medi-Cal (SD/MC)" services and "Fee for Service/Medi-Cal (FFS/MC)" services, a distinction that largely refers to the provider type and billing system used by that provider. These MHPs may use their own staff and/or contract with providers to provide services. If the MHP contracts with providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered.

The MHPs are governmental entities and utilize certified public expenditures (CPE) as the non-federal share of the SD/MC services.

Claims Processing and Payment for SD/MC Mental Health Services

Claims for SD/MC mental health services are processed through two computer systems – the DMH Short Doyle/Medi-Cal system (SD/MC system) and the DHCS claims payment system contractor Electronic Data Systems (EDS[1]). Counties submit batches of individual claims to the SD/MC system and receive a batch number for tracking the claims information. The DMH does preliminary edits of the claims and electronically transfers the claims data to the DHCS Information Technology Services Division (ITSD) for processing by EDS. The EDS system determines whether the claims meet program requirements such as recipient eligibility, provider eligibility, and the payment rate for the service. After processing the claim against the edits, EDS determines whether the claims are approved, denied or suspended.

The claims, along with three reports, are electronically transferred to DMH. The three reports are the Explanation of Balance (EOB), the preliminary Approved Services Report (ASR), and the Error Correction Report (ECR). The EOB report contains detailed information[2] and is used by DMH to invoice DHCS for the FFP portion of payments to counties. DMH uses the EOB report because it contains the detail information to allow DHCS to report SD/MC costs in accordance with CMS requirements e.g., Medicaid Eligibility Group, type of service, and date of service.

The ASR contains summary information by county, by program type[3], and by the fiscal year the service was provided. The ASR is used by DMH to determine the amount of FFP to be paid to the counties for the mental health program. DMH uses the ASR data to pay the counties because it met their needs when the accounting portion of the SD/MC system was developed.

The ECR contains information about what needs to be changed on the claims that have been suspended or denied in order to make them payable. It is used by the counties to correct their claims or submit additional documentation and obtain payment from DMH.

Although, in theory, the ASR and the EOB should have the same totals, our testing revealed that the two reports do not contain the same totals. The SD/MC system lacks the functionality to allow DMH to reconcile the two reports.

SD/MC Cost Reporting and Settlement Process

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[1] DHCS contracts with a fiscal agent, Electronic Data Systems, to process claims through the Medicaid management information system (MMIS).
through the MMIS

[2] Information contained on the EOB report includes identification information for both the recipient and the provider, demographic (age, eligibility code, sex, etc.) information for recipient, and services provided information (scope, duration and date).

[3] Program type includes SD/MC, SCHIP, MCHIP, Refugee and state-only claims.

The MHP's are required to submit cost reports to DMH by December 31st following the close of its fiscal year. The cost report package must include separate, detailed cost reports for each MHP and certain contract providers who meet certain requirements. The cost report serves four primary purposes: (1) to compute the cost per unit for each service function; (2) to determine the estimated net allowable Medi-Cal costs (FFP) for each legal entity; (3) to identify the sources of funding; and (4) to serve as the basis for the year-end cost settlement and fiscal audit.

To determine allowable Medi-Cal costs, the cost report first calculates the total allowable cost by taking adjustments for non-mental health related expenses. Once allowable costs are determined, the costs are apportioned between utilization review, administrative, and direct service costs. The direct service costs are then allocated between Medi-Cal and non-Medi-Cal services. To determine the average costs per unit of service, the total costs are divided by the number of service units. To determine total cost by program, the average cost per unit is multiplied by the service units provided to the program (Medicaid, State-only or SCHIP).

There are two types of cost settlement – the interim settlement and the final settlement. The interim settlement occurs when counties submit the year-end cost reports to the DMH. The interim cost settlement is completed upon receipt of the cost report. The final cost settlement occurs approximately 4 to 5 years following the submission of the county cost reports. It is during final settlement that the DMH performs compliance audits of the county cost reports. At final settlement overpayments may be identified and offset against current claims for collections.

METHODOLOGY & SCOPE

We conducted our fieldwork September 18-20, 2006. To accomplish our objectives we:

- Reviewed applicable State and Federal laws and regulations and the State plan amendment;
- Reviewed DMH documents, including program instructions, claims processing and cost reporting procedures;
- Tested the total of the detail file provided to support the line 7 adjustments;
- Reviewed the State claim schedules and supporting documentation;
- Reviewed cost reports to understand the cost settlement process; and
- Reviewed contracts between the DMH and counties.

FINDINGS

1. The State was unable to support an additional $8,533,137 of the beneficiary mental health service costs reported on the June 30, 2006 CMS-64.

Federal regulations at 42 CFR §433.10 provide for federal matching payments for part of a State's expenditures under an approved State plan. The CMS-64 line 7-increasing adjustment violated this requirement by claiming $8,533,137 for federal reimbursement for claims that had not been paid by the DMH for FY 2003/2004 services.

The over-claiming was identified by CMS staff during the review and is the result of DMH using the EOB report to bill DHCS for mental health services but using the ASR to pay the counties. The total on the ASR file provided to CMS for sample selection did not match to the total claimed as a Line 7-increasing adjustment. The net difference between the two files was $8,533,137. We found that the EOB file contained these amounts that did not represent actual payments made by DMH to counties for mental health services. As a result, DMH understated the overpayment computation by $8,533,137.

Using different data sources to bill DHCS for the federal financial participation and pay to the counties creates a risk that the amount billed to DHCS does not reconcile to the actual payments to the counties. For the short term, DMH has attempted to eliminate this risk by holding payments to counties until the matching FFP is received from the DHCS billing. For the long term, DMH is designing improvements to the SD/MC system to either reconcile the EOB to the ASR or use the same data source to pay the counties and to bill DHCS for the federal share.

2. DMH non-Title XIX (i.e., Title XXI or State-only programs) and administrative expenditures have been inappropriately claimed as Title XIX Medical Assistance Payments.

Federal regulations at 42 CFR §433.10 and §433.15 describe the different FFP matching percentages for medical assistance and administrative expenditures incurred by the State Medicaid Agency. CMS' review of cost settlements claimed on the June 30, 2006 CMS-64 found that some costs claimed at the medical assistance percentage were related to Medicaid administrative costs, SCHIP expenditures and/or State-only programs. Upon further review of cost settlements for FY 01/02, 02/03, and 03/04, we found approximately $12.36 million had been claimed at the Medicaid medical percentage when the cost was either an SCHIP cost or a State-only cost. Of this amount, $10.36 million was for State-only programs and $2 million was for SCHIP costs. Some of the payments for cost settlements have been deferred since the quarter ending June 30, 2006, and CMS continues to work with the State.

These errors occur because DMH submits an invoice to DHCS for payment showing a consolidated settlement total. CMS has since had several meetings with both DHCS and DMH to discuss changes to this process. CMS will continue to work with the State to resolve the deferred funds.

3. DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total expenditures for the Section 1915(b) mental health waiver reported on the CMS-64 forms to likely be significantly misstated.

Federal regulations at 42 CFR §433.32 require that the State Medicaid agency maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements. During our review, we found that the DHCS and DMH systems are not adequate to comply with federal reporting requirements. We identified the following additional issues:

1. DMH's policy of off-setting amounts due from counties for prior-period audit settlements against current-period claims results in inaccurate reporting of year-by-year amounts because it does not appear that this detail is made available to DHCS. On a weekly basis, the DMH runs a report that provides a listing of outstanding overpayments that must be refunded to the federal government. When an overpayment exceeds the county claim, the DMH allows an offset for part of the overpayment. If a county's subsequent claim for reimbursement is insufficient to repay the remaining balance of the overpayment, future claims are offset against the overpayment until it is resolved. Costs by waiver year, necessary to determine whether or not the waiver is cost-effective, are not accurate because the county overpayments are not reported to DHCS.

2. The coding of costs to the DMH accounting system may contain errors that result in the miscalculation of expenditures. We identified a significant error in the reporting of Santa Clara County's SFY 03/04 cost settlement. It appears that DMH coded the $6,079,057 amount due to the county for SD/MC services as "Community Svcs – Other Treatment", the State-only portion. DMH then coded the $32,565 due for the State-only program as SD/MC. We notified DMH of this error but are unsure whether this was corrected on the CMS-64. If the error is not corrected, the State would have under-reported allowable Medicaid costs by $6,046,492 ($6,079,057 recorded as a State-only cost minus $32,565 recorded as Medicaid cost).

To date, DHCS has returned additional overpayments in excess of $150 million FFP for SFY 04/05 mental health services. The State continues to reconcile all payments made for SFY 05/06 to determine if additional overpayments occurred during this period.

4. DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices.

Federal regulations contained at 42 CFR §431.10 specify that a State must designate a single State agency established or designated to administer or supervise the administration of the Medicaid program. DHCS has been designated as the single State

agency for administering the California Medicaid program, and is, therefore, responsible for its oversight. The lack of oversight appears to have directly contributed to the overpayment that is the subject of this review. We noted the lack of basic controls at DHCS such as a reconciliation between the claims authorized for payment and the amount of FFP claimed on the CMS-64 reports. DHCS also receives very limited supporting documentation for amounts claimed and does not verify that amounts Medicaid funds being authorized for payment are for Medicaid services, as discussed in the cost settlement finding above.

We are aware that DHCS had been working to strengthen controls over this process and will provide any technical assistance needed to help improve oversight.

RECOMMENDATIONS

1. DHCS must return the additional $8,533,137 FFP in overpayments.

DMH indicated agreement during our review that the $8,533,137 represents the amount of expenditures included in the initial SFY 2003/2004 reconciliation that was not supported by payments to counties. DHCS should make a line 10B decreasing adjustment on the most current CMS-64 to return this FFP to CMS.

THE STATE'S COMMENTS

The State agreed that there was an overpayment but requested additional time to review the SFY 2003/2004 beneficiary mental health services costs to determine the amount needing to be returned to CMS. CMS is unable to approve this request and requests that DHCS make the Line 10B adjustment for $8,533,137 within 60 days in accordance with 433.312. If the State's review results in changes to the overpayment amount, adjustments can be made in accordance with 42 CFR 433.312(f). A copy of the State's response is attached to the report.

2./3. DMH must review the DMH cost settlements reported for SFY 01/02, 02/03, and 03/04 and return Title XIX Medicaid FFP claimed for State-only programs and SCHIP. We estimate the total adjustment will be $12.42 million in FFP. We also recommend that DHCS implement controls to properly report cost settlement amounts.

DHCS is claiming Medicaid costs for expenditures related to non-Medicaid programs. The estimated amount due for State-only programs and SCHIP was developed from a summary report prepared by DMH accounting for the last three fiscal years which specified the amounts for each program. The summary document did not contain sufficient information to determine the allocation between allowable Medicaid medical service cost and administrative costs. DHCS needs to strengthen controls over this process to ensure that claims are properly paid and reported on the CMS-64 reports.

THE STATE'S COMMENTS

The State agreed to review the cost settlement amounts for SFY 01/02, 02/03, and 03/04 to determine if any Title XIX FFP must be returned to CMS. The State also described the changes to the cost settlement reporting process that were being made to comply with Federal reporting requirements. A copy of the State's response is attached to the report.

4. We recommend the State implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The lack of DHCS oversight appears to have directly contributed to the overpayment that is the subject of this review. We are aware that DHCS had been working to strengthen controls over this process and will provide any technical assistance needed to help improve oversight.

THE STATE'S COMMENTS

The State described significant changes to the invoice processing and review procedures for mental health services. A copy of the State's response is attached to the report.

DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services

ARNOLD SCHWARZENEGGER
Governor

NOV 14 2008

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Dear Ms. ~~Nagle~~ Gloria

The California Department of Health Care Services (DHCS) has prepared its response to the draft report entitled "Review of California Department of Mental Health Over-Billing in the Short Doyle Medi-Cal Program for State Fiscal Year 2003/2004" (Control Number 09-FM-2006-CA-003 DMHOP). The DHCS appreciates the work performed by the Centers for Medicare & Medicaid Services and the opportunity to respond to the draft report.

Please contact Mr. Irvin B. White, Jr., Chief of the Medi-Cal Benefits, Waiver Analysis and Rates Division, at (916) 552-9619 if you have any questions.

Sincerely,

Stan Rosenstein
Chief Deputy Director
Health Care Programs

Enclosure

Response to the Centers for Medicare & Medicaid Services
Draft Report Entitled

"Review of California Department of Mental Health Over-Billing in the Short Doyle Medi-Cal Program for State Fiscal Year 2003/2004"

Finding:	The State was unable to support an additional $8,533,137 of the FY 2003/2004 beneficiary mental health service costs claimed on the June 30, 2006 CMS-64. This was due to the inclusion of claims that had not been paid by the DMH for FY 2003/2004.
Recommendation:	DHCS must return the additional $8,533,137 FFP for FY 2003/2004 overpayments.
Response:	DHCS and DMH agree that there was an overpayment; however, DMH requests the opportunity to further review the state fiscal year (SFY 2003/2004) beneficiary mental health services costs claimed on the June 30, 2006 CMS-64 and determine the amount that must be returned through a Line 10B Adjustment on the CMS 64 Report.
Finding:	DMH non-Title XIX (i.e., Title XXI or State-only programs) and administrative expenditures have been inappropriately claimed as Title XIX Medical Assistance Payments.
Recommendation:	DHCS must review the DMH cost settlement reported for SFY 01/02, 02/03, and 03/04 and return Title XIX Medicaid FFP claimed for State-only programs and SCHIP. We estimate the total adjustment will be $12.42 million in FFP. Of that amount, DMH has calculated that $2.06 million is allocated to SCHIP.
Response:	DMH will review the cost settlement amounts for SFY 01/02, 02/03, and 03/04 to determine the Title XIX Medicaid FFP amount that must be returned to CMS.
Finding:	DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health consolidation waiver expenditures reported on the CMS-64 forms to likely be significantly misstated.
Recommendation:	We recommend that DHCS implement controls to properly report cost settlement amounts between programs as well as between MAP and ADMIN and waiver versus non-waiver.

Response: DHCS and DMH are currently drafting a Cost Settlement Report form that will break out and report cost settlement costs in a format consistent with federal reporting requirements.

Cost Settlement Reports for state fiscal years prior to and including SFY 06/07 will contain a breakdown of the different funding streams (i.e. Title XIX, Title XXI, and State-only programs). For state fiscal years 07/08 and beyond, Cost Settlement Reports will also include the Medical Eligibility Groups (MEGs), the various administrative funding streams, as well as the appropriate Service Categories.

For SFY 07/08 and beyond, the line items in the Cost Settlement Reports will be broken out as follows:

- Administrative Costs OA 50% / 75%
- Administrative HIPPA
- Medi-Cal Administrative Activities 50% / 75%
- MHP OA (County Administration)
- MHP Quality Assurance and Utilization Review
- San Mateo Pharmacy
- San Mateo Lab
- Beneficiary Services (Short Doyle Medi-Cal)
- MCHIP 65%
- Healthy Families 65%
- Refugee 100%

Finding: DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices.

Recommendation: We recommend that the State implement procedures to ensure adequate oversight and review of amounts claimed as Medicaid mental health costs.

Response: DHCS has developed invoice processing procedures for the adequate review of invoices submitted to DHCS by DMH.

DHCS has developed a data base for tracking the DMH invoices. This data base will identify duplicate DMH claim schedule numbers and allow DHCS to identify invoice duplicate payment amounts. This data base will capture the invoice information including claim schedule numbers. A claim schedule filter will be conducted to ensure that such invoices have not been already submitted by DMH and paid by DHCS.

In addition, DHCS has implemented a quarterly reconciliation process for SFY 03/04 and beyond to reconcile expenditures and reimbursements.

This process will:

- Monitor the DMH expenditures and reimbursements
- Identify and correct any incorrect invoice information
- Identify issues and trends requiring DHCS intervention
- Identify any DMH overpayments or duplicate payments which must be returned to CMS
- Verify that such overpayments are returned to CMS
- Properly report the DMH expenditures and reimbursement on the CMS 64 Expenditure Report & the CMS 21 Expenditure Report (for Healthy Families)

The DMH Quarterly Reconciliation Report will also be utilized by DHCS to verify that the cost settlement costs are correctly reported by using the paid claims information from the Quarterly Reconciliation Report as the basis for determining the subsequent final cost settlement adjustments. Also, this final revised Quarterly Reconciliation inclusive of final cost settlement adjustments will identify any final cost settlement overpayments and verify that these overpayments are returned to CMS.

The Quarterly Reconciliation Reports cover the following timeframes:

Quarter 1 October 1 – December 31
Quarter 2 January 1 – March 31
Quarter 3 April 1 – June 30
Quarter 4 July – September 30

DHCS and DMH are also working on implementing the SD/MC Phase II Electronic Claims Processing System improvement project. The new Phase II electronic claims processing system will eliminate many of the over billing issues caused by incorrect data downloads.

It is envisioned that this system will:

1. Allow for adjudication of claims received from the county mental health plans (MHPs) as soon as they are electronically or manually received by the state rather than the state having to rely on slower "batch processing" of claims once per week.

2. Be fully compliant with federal Health Information Portability and Accountability Act (HIPAA) electronic data requirements. Phase II will eliminate the need for DHCS' HIPAA Translator which currently causes delays in claims processing, risks overall SD/MC system failure, lacks developer support and sufficient memory allocation, and requires state staff and consultant resources to operate.

3. Directly calculate both the state General Fund (SGF) and Federal Financial Participation (FFP) amounts owed to county MHPs when claims are approved by Phase II.

4. Maintain records of separate SD/MC claims processing tasks/sub-programs, thus allowing the state to:

    a. establish performance benchmarks for Phase II sub-programs
    b. more effectively monitor and oversee the efficiency of the new system in processing claims on an accurate and timely basis
    c. provide county MHPs with status updates on their submitted claims

The project implementation date is scheduled for March 2009 and will address and comply with all federal reporting requirements.